Payment Of Compensation Without Award

(Longshore and Harbor Workers' Compensation Act, as extended)

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No. 1215-0022

NOTE: This Notice is to be filed with the District Director when the first payment is made. A copy should be sent to the person to whom compensation was paid. This report is mandatory (33 U.S.C. 914(c). Failure to report may result in delays in the delivery of benefits. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

FOR OFFICE USE

1. OWCP No.

2. CARRIER'S No.

3. Name of injured person (First, middle, last - please print or type)

4. Address of injured person (Number, street, city, state and ZIP code)

5. Date of accident or first illness (Month, day, year)

6. Date disability began (Month, day, year)

7. Name of injured, or dependents of injured, to whom compensation will be paid

8.

Average weekly wage $ _____ multiplied by 2/3 = compensation rate $ _____

(Mark if maximum rate is being paid) ☐ Yes

9. Compensation will be paid from - Enter month, day, year.

_____

until notice is given that payment has been stopped or suspended

10. Date of first payment (Month, day, year.)

11. Has medical care and treatment been provided by a physician or hospital chosen by the injured person?
(Mark appropriate box) ☐ Yes ☐ No

12. Name of employer

13. Address of employer (Number, street, city, state and ZIP code)

14. Name of insurance carrier

15. Authorized signature

16. Title of person whose signature appears in item 15

17. Date signed

Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Division of Longshore and Harbor Workers' Compensation, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.